UTAH STATE DEPARTMENT OF HEALTH
Division of Children's Services
44 Medical Drive
Salt Lake City, Utah
84113

Application for Services

Name_____ Parent Name_____

Address_____ City_____ County_____

Date of Birth_____ Sex_____ Race_____ Telephone_____

History (brief outline of presenting problem, including reason for referral)

Physical Examination:

General Appearance:_____

_____

Head, EENT:_____

_____

Chest:_____

Lungs:_____

Heart:_____

Abdomen:_____

_____

Extremities:_____

Tentative Diagnosis:_____

_____

_____

SDH-CS-11/1/65 (over)

SDH-CS-1-R./65

Parent consent for referral:

We authorize the Division of Children's Services of the Utah State Department of Health to perform the necessary diagnostic examination to recommend treatment or to recommend and provide treatment for the above child.

Signature:_____
Parent or Legal Guardian

Physician's request for referral:

☐ Diagnostic Consultation

☐ Diagnostic consultation and treatment (should patient meet the eligibility requirements)

Signature_____M.D.

Address_____

Date_____

Please send application to:

Utah State Department of Health
Division of Children's Services
44 Medical Drive
Salt Lake City, Utah 84113

Telephone 322-2431

Additional forms may be obtained by physicians at above address.

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